White, W. L. (2013). Recovery mobilization in Ghana: An Interview with Edwin Ahadzie. Posted at www.williamwhitepapers.com.

Recovery Mobilization in Ghana: An Interview with Edwin Ahadzie

William L. White

Introduction

Recovery advocacy and recovery support activities are increasing in many areas of Africa. I have been particularly interested in such efforts in Ghana and in the fall of 2013, had the opportunity to interview Edwin Ahadzie, who is a central figure in the recovery mobilization movement in Ghana. Please join us in this conversation.

Bill White: Edwin, could you begin by describing how you got involved in addiction recovery support activities in Ghana?

Edwin Ahadzie: It goes way back to my own problem with alcohol and drugs, which has been a struggle for me for more than twenty years. I struggled to get sober at a time few recovery supports existed in Ghana. There was basically the psychiatric hospital since there was no place to go to seek addiction treatment and no AA meetings or other peer recovery support groups. So I found myself going in and out of the psychiatric hospitals over a span of twenty years. In my attempts to sober up, I tried so many things to solve this problem. I even went to a prayer camp. Some of these camps also treated people with mental problems. I had the experience of visiting one such place. It got to a point where my relatives got very desperate because I tried so many things that didn't work. So, at one of the psychiatric hospitals where I went through a detox spanning 3 weeks, I was taken to the doctor's office and sedated upon discharge. When I woke up, I found myself in a very strange room. I tried to move and realized that one leg had been chained to a metal post at the ankle level. There were about five other men in the same condition in the room. Initially, I thought I was dreaming, but later, I found out it was real and when I asked, I was told it was a prayer camp.

The belief there was that addiction is caused by demons that have taken over the person's body and made them drink or use drugs and do bad things. The only way out in their view was to exorcise these demons through prayer and fasting. At this place, where it rained almost every day, some of the mentally insane had been chained to trees. It was the belief that such harsh treatment helped chase out these demons. I wasn't very happy about being confined in chains and decided to escape. The chain was secured by a big padlock to a metal post and every night when the others were fast asleep, I used a spoon to saw through the padlock for about 3 hours. After three weeks, I was able to cut through the padlock to a point where just another night's job would complete the process. But alas, my escape plan never became a reality! On that fateful day that was to be my day of freedom, the caretaker came round inspecting our padlocks and realized what I was planning to do. My padlock was then replaced with a much bigger and thicker one. I've heard about the existence of other such camps in other parts of the country. Most of them have since been abolished, but I believe a few might still exist. Believing that the problem of

alcoholism and drug addiction is spiritual (demonic), people take their relatives to spiritualists to cast out the demons.

After repeated help from both family and friends, and many more trips to psychiatric hospitals, had failed to provide any lasting solution, a glimpse of hope finally materialized. This was during my very last visit to the psychiatric hospital, where I found a twelve-step meeting, which was facilitated by members of Hopeful Way Oxford House (HWOH), situated close to the hospital. I started to attend these meetings and went on to live at the HWOH after I left the hospital. By this time, I had begun getting a better understanding of my problem and started working on a solution through the 12-steps.

In 2009, under the auspices of Hopeful Way Foundation (HWF)—an NGO that provides and supports treatment and recovery from alcoholism and drug addiction—Byron Merriweather, an Oxford House Outreach Worker from Virginia, opened the first Oxford House (OH) in Ghana and the only one in the whole of Africa. I transitioned to HWOH on the 31st of January, 2011. At HWOH, I began to develop leadership qualities through serving as secretary, treasurer, and then as president. I also volunteered as an "Extension Worker" for HWF and my duties involved helping to start more twelve-step meetings, creating public awareness about these meetings and the OH, and developing a mutual relationship with the health institutions and professionals. Over the past two to three years, we have had people in the recovery community in the US come to Ghana to share their experience, strength, and hope, and to help us build a better foundation in our efforts at establishing a strong recovery environment. They include the likes of Dr. Al Mooney of Willingway Foundation, who has visited Ghana twice in the last couple years and who arranged for Dr. Eugene Dordoye and myself to study at Willingway Hospital in Statesboro, Georgia.

Dr. Thomas Kimball, newly appointed as head of the Center for the Study of Addiction & Recovery (CSAR) at Texas Tech University (TTU), and Emily Eisenhart of Georgia Southern University, have also visited Ghana twice with their groups of students and faculty members in recovery and have been of much assistance. Through continued collaboration with HWF and the ever-growing need to expand and strengthen advocacy and support systems for recovery in Ghana, these two universities will again visit in 2014. We also receive very good cooperation from the addiction professionals at Pantang Psychiatric Hospital, Accra Psychiatric Hospital, and Korle Bu Teaching Hospital. Larry Gaines of Kelly Foundation & Serenity Park in Little Rock, Arkansas, has also played a key role in our recovery efforts. House of St. Francis (HSF), a new treatment facility for men which opened in August 2012, is modeled after Serenity Park. Recovery Dynamics (RD), the flagship of Kelly Foundation, is the main treatment program used at HSF in addition to the therapeutic community concept.

After experiencing a number of challenges—due to my drug-related escapades in the past—in obtaining a US visa, I was able to attend the workshop training in RD at Serenity Park from mid-May through July, this year. Prior to my coming to the US, I left the HWOH in September 2012 to assist Byron, who had had the RD training earlier that year, in running HSF. It was a big challenge stepping up to the role of assisting Byron to teach RD and holding the fort when he had to return to the US to renew his visa. The HSF is the property of the Catholic Archdiocese of Ghana and is run by HWF. A board comprising members from both institutions, together with a few other individuals, was inaugurated earlier this year.

Bill White: Edwin, does the government fund addiction treatment or recovery support services in Ghana?

Edwin Ahadzie: Unfortunately, not much is being done. Although there are others who are also trying to treat alcoholism and addiction, these efforts are small. Most of the resources that go to fund treatment and recovery support activities are provided by the church. There exist very few treatment centers in Ghana. Despite the bleak picture, recent efforts by the Narcotics Control Board of Ghana (NACOB) to vigorously embark on demand reduction strategies and policies are an indication that the Government is beginning to take a keen interest in the problem.

Bill White: You mentioned that there were no AA or other recovery support groups early on. Are those more available now in Ghana?

Edwin Ahadzie: Yes, we have about ten to eleven AA meetings and a couple of NA meetings, but they are all mainly concentrated in the nation's capital, Accra. Outside of Accra, there exist hardly any meetings, but efforts are being made currently to expand these meetings to other parts of the country. Unfortunately, in order to still keep these meetings active, the same old faces have to be in attendance. When a new meeting is started in another part of the city, we need people from that area to attend and take ownership, but that doesn't happen. There is also the problem of stigmatization associated with drug addiction and alcoholism.

Bill White: How would you describe public attitudes towards addiction and recovery in Ghana?

Edwin Ahadzie: Drug or alcohol addiction is a disease but unfortunately most people, including health professionals, are ignorant of this fact or refuse to accept the disease concept. They continue to see it as a moral weakness. When I was in treatment, which was basically a detoxification process and sometimes a few counseling sessions with a clinical psychologist, they told you, "Don't use alcohol or drugs anymore." That didn't work for me. I just kept going in and out and in and out of such types of treatment. But today, we know that it is a disease and not a moral weakness and we try to tell people how they can find help from the twelve-step meetings, HSF, and the OH.

When we conduct public information workshops, a lot of people come up to inquire how their family members who have a problem can be helped. Some members of HWOH have come to the house through such platforms. But surprisingly, we don't hear again from most of these same people who had desperately inquired about help for their loved ones. Stigmatization, as I mentioned earlier, makes it difficult for people to follow up on addressing the problem. The African traditional family unit is very extensive and includes all of the grandparents, uncles, aunties, and cousins, etc. This sometimes makes it difficult for people to make decisions involving a member of the immediate family unit without the approval of the extended family. Preserving a good, unblemished family name takes precedence over every other thing. These attitudes make it very difficult for people to access help.

An American with a Ghanaian wife owns a property that was running as a second OH, but certain challenges resulted in it being closed down. This couple tried to sober up an alcoholic who was in a really bad state but experienced serious resistance from the extended family. People don't like to talk about the alcoholics and addicts in their family for fear of disgrace; however, they forget that it is not a secret because people already know if someone is a hopeless drunk or addict.

I remember in 2011, when Dr. Al Mooney visited Ghana, we had a public information talk at the Sunday service of one Catholic Church. We were given the opportunity to talk to the congregation about alcoholism, and some of us even shared our personal stories. After the church service, the deacon offered to serve alcohol to us as refreshment. Previously, we had enquired of him if any members of the congregation or their family members may have a drinking problem. He replied with a big, "No." We noticed that it was a tradition for some of the church members to patronize a drinking parlor sited within the church premises.

Bill White: Are alcohol and drug problems presently increasing in Ghana?

Edwin Ahadzie: Yes, it is assuming alarming proportions. Alcoholism is a very serious problem, especially in the villages where the occupations are predominantly farming and fishing. Lots of myth surround drinking. Drinking is associated with manliness. The women believe that alcohol is the best remedy to combat menstrual pains. It is also a general belief that alcohol helps boost one's appetite. And alcohol is built in to so many rituals, festivals, and activities. Funeral activities are almost always major events every weekend with people engaging in excessive drinking. Praying in the traditional way involves the use of alcohol, i.e., pouring libation. This is done as an offering to the deities or gods and ancestors of the land. After the prayers are said, tradition demands that the drink is passed round for everyone to take a sip or gulp. In the cities, the situation is no different. More and more of the youth are experimenting with different kinds of drugs. Now, there is an increasing influx of some of the newer drugs into the country. Abuse of and addiction to prescription medication is also becoming a matter of great concern especially among health workers. NACOB tries to monitor chemicals that are imported into the country and track their usage since it's been known that some people could use these chemicals as base ingredients to manufacture synthetic drugs.

Bill White: What do you see as most critical in Ghana's needs right now in terms of treatment and recovery support?

Edwin Ahadzie: Well, the number one priority is for the government to take a keen interest in addiction treatment and provide support to the already existing treatment facilities as well as the incentive to establish more of the same. As I said earlier, NACOB is collaborating with these facilities in its attempt at demand reduction as opposed previously to solely supply reduction, i.e., arresting the drug traffickers. It has also taken the initiative of formulating policy guidelines to standardize and ensure best practices for drug and alcohol addiction treatment. One human resource that is indispensable in the provision of quality treatment is the substance abuse counselor, which we lack. We also need to expand the Oxford House concept by opening more houses for both men and women. We need to create public awareness about the problem and the treatment opportunities that exist. We can learn from the new video, "The Anonymous People," the most effective ways to carry the message of hope into the public domain. We are most grateful to Faces & Voices of Recovery for providing HWF/HSF with a copy of the DVD.

Bill White: What do you feel best about in terms of what you've done to expand recovery support services in Ghana?

Edwin Ahadzie: My story speaks volumes of the new life that is possible in recovery and resounds the message of hope to the afflicted and still suffering ones. At the HSF, we have trained and motivated Ghanaians to overcome their addiction to drug and alcohol. Some of these people are now in leadership positions and are carrying the recovery message back home. One example is the very first client at HSF who has graduated from the treatment program and is now a peer counselor teaching RD at HSF. Another graduate from the HSF has been able to start two twelve-step meetings—an AA & NA meeting—in another part of the country where he hails from. He had the opportunity to represent Ghana at the NA conference in Dar-es-Salaam. Seeds have been planted that are beginning to bear fruit and create a ripple effect. Despite the challenges we continue to face, we have been able to add a few more AA and NA meetings. At HSF, we have started monthly family workshops for the families of the clients and this has been very helpful in teaching them about addiction and how they need to relate to the addict in active addiction, treatment, and recovery.

Bill White: Edwin, if some of our readers wanted to contribute to the financial support of House of St. Francis or other treatment and recovery support programs in Ghana, how would they go about doing that?

Edwin Ahadzie: We are in need of funds to pay for low income Ghanaians to receive residential treatment at HSF. We are also in the process of establishing an OH for women and children but need funds to purchase furniture, kitchen appliances, and to help pay for rent for the first year. We can be reached through the Hopeful Way Foundation website (http://hopefulwayghana.blogspot.com). Tax deductible donations can also be sent through Dr. Al Mooney to:

Willingway Foundation
Attn: Jenny Mallard
(for Ghana project)
311 Jones Mill Road
Statesboro, Georgia 30458

We would be happy to have people with good recovery contact us about the possibility of coming to Ghana to assist at HSF and to see the wonderful and beautiful culture of West Africa.

Bill White: Edwin, thank you so much for taking this time to talk about your life and work. My very best wishes to you during your continued time in the United States and in your continued work in Ghana.

Acknowledgement: Support for this interview series is provided by the Great Lakes Addiction Technology Transfer Center (ATTC) through a cooperative agreement from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT). The opinions expressed herein are the view of the authors and do not reflect the official position of the Department of Health and Human Services (DHHS), SAMHSA, or CSAT.